APPENDIX D – Mandatory Responses to Technical Components of the RFP

1. Organization Overview and Overview of Relevant Experience

Section 1 Point Allocation	
Question(s)	**Points**
1	7
2	18
3-6	20
7-9	5
Total	50

1.1. Corporate Overview

Q1. Include in the Proposal a summary of the Respondent's organization, management, and history and how the Respondent's experience demonstrates the ability to meet DHHS's needs, as described throughout this RFP and MCM Model Contract. At a minimum, the response should include the following information:

1) A general overview of the Respondent organization;

2) Information regarding the Respondent organization's ownership and subsidiaries;

3) Information regarding the Respondent organization's background and primary lines of business;

4) The number of employees employed by the Respondent;

5) The Respondent organization's headquarters and satellite locations;

6) The Respondent's current project commitments;

7) The Respondent's major government and private sector clients; and

8) The Respondent's mission statement.

1.2. Managed Care Experience and References

Q2. Provide a list of all current and/or recent (within five (5) years of the issue date of this RFP) contracts for managed care services (e.g., medical care, integrated physical and behavioral health services, pharmacy, Early and Periodic Screening,

Diagnostic and Treatment services (EPSDT), Care Management and Care Coordination services), including the Respondent's parent, affiliate(s), and subsidiary(ies). Include in a table the following information for each identified contract:

1) The Medicaid population(s) served (e.g., children, parents, non-elderly and non- disabled, Aged, Blind, Disabled);

2) The number of enrollees, by health plan type and population type;

3) The name, address telephone number and website of the client;

4) The specific start and end dates of the contract;

5) A brief narrative describing the role of the Respondent organization and the scope of work performed, including covered services;

6) The use of administrative and/or delegated Subcontractor(s) and their scope of work;

7) The annual contract amount (payment to the Respondent) and annual claims payment amount;

8) Whether the contract was/is capitated, fee-for-service, or another payment method (if another payment method, the method should be described);

9) The scheduled and actual completion dates for contract implementation and – if applicable – any boundaries that hindered implementation and the solutions employed to address those challenges; and

10) The accomplishments and achievements the Respondent wishes to highlight.

Q3. Indicate four (4) prior engagements to be used as references, for which: at least two (2) should be state agencies, preferably state Medicaid agencies, including (if applicable) at least one (1) state Medicaid agency with which the Respondent's contract included a "carve-in" of behavioral health services; at least one (1) should be a Provider; and at least one (1) should be a community-based organization. Highlight in the response examples that demonstrate the Respondent's experience with the key priorities indicated by DHHS throughout the MCM Model Contract and noted in Section 2.2 (Goals of the MCM Program) of the RFP. The Respondent may *not* submit a reference that is employed by the State of New Hampshire. DHHS intends to contact these references and consider the information obtained as part of the scoring process. By submitting the references, the Respondent is specifically authorizing DHHS to contact them regarding this procurement, their Proposal, and any and all information the reference has regarding the Respondent. To the extent a written authorization or release is required by any reference

provider, the Respondent agrees to provide one upon request. For each selected reference, the Respondent should include the following information:

1) The type of reference (e.g., state Medicaid agency, Provider);

2) The reference's name, title, and employer (again, the reference may not be employed by the State of New Hampshire)

3) The reference's contact information, including phone number, email address, and physical address;

4) The nature of the relationship, including the capacity in which the reference is familiar with the Respondent organization;

5) The time period of the relationship; and

6) Activities undertaken during the engagement that establish the Respondent's qualifications for this RFP.

Q4. Identify and describe all instances of non-compliance that the Respondent, its parent organization, and its affiliates have encountered as part of any Medicaid managed care contracts within the past three (3) years. For each non-compliance issued, the Respondent shall indicate the type of non-compliance issued, the date the non- compliance was issued, and the reason the non-compliance was issued, the issuing state(s) in which the Respondent was providing services for which the non-compliance was issued, and any and all details of the sanctions applied against the Respondent as a result of non-compliance.

Q5. Respondent shall identify any and all instances of non-renewal or early termination of contracts with states. The Respondent shall specify the type of contract, why the termination was initiated, and by whom it was initiated (contractor, state, mutual, or federally imposed).

Q6. For purposes of responding to Question 4 and Question 5, types of non-compliance include: compliance letters (includes Warning Letters, Notices of Non-Compliance, Corrective Action Plans (CAPs) or similar state notices); adverse performance audits (contracts failing more than fifty percent (50%) of audit elements); adverse financial audits (adverse opinions or disclaimed reports); failures to maintain fiscally sound operations (negative net worth or financial loss greater than half of the contractor's total net worth); exclusions enforcement actions (imposed by CMS as an intermediate sanction); and all other significant compliance concerns.

Q7. Submit an organizational chart and a staffing plan for the MCM program. The organizational chart and staffing plan should clearly indicate how the Respondent plans to meet all MCM Model Contract staffing requirements.

Q8. Describe the Respondent's intended on-site presence in New Hampshire.

Q9. For Key Personnel currently on staff with the Respondent, as described in the MCM Model Contract, please provide the name, title, qualifications, and resume for each individual. For staff to be hired, please describe the hiring process and the

qualifications for the position and include the job description associated with each to-be-hired employee. DHHS reserves the right to accept or reject dedicated staff individuals.

2. Subcontractors

Section 2 Point Allocation	
Question(s)	**Points**
10(1) through (3)	10
10(4) through (11)	15
Total	25

Q10. Please indicate whether the Respondent intends to Subcontract with any Subcontractors to perform portions of the obligations described in the MCM Model Contract, or otherwise proposed by the Respondent. DHHS reserves the right to accept or reject Subcontractors. For each function that the Respondent plans to contract with a Subcontractor for, please provide the following information:

1) (i) The portions of the work to be performed by a Subcontractor; (ii) the name, address, and location of such Subcontractor; (iii) the general terms of the Subcontractor agreement, including the amount, duration and scope of services; and (iv) how the Respondent intends to provide oversight of Subcontractor;

2) A description of the Subcontractor's experience providing those services;

3) If applicable, a description and actual copies of the relevant licenses, certifications or permits the Subcontractor has and maintains that are necessary for it to perform the services;

4) A description of how the Respondent will monitor the performance of its Subcontractors to ensure all MCM Model Contract requirements are met;

5) Sample performance monitoring reports;

6) Sample reports showing any actions taken to improve performance and ensure positive results;

7) A description of the information or data the Respondent will exchange with its Subcontractor(s) and how that information or data will be transferred;

8) If applicable, a description of how Subcontractors are integrated with Care Management programs;

9) If applicable, a description of how Subcontractors are integrated with third-party recovery and/or fraud and abuse programs; and

10) A description of any sanctions or penalties that apply if the Subcontractor fails to perform up to the Respondent's expectations.

11) Signed letters of commitment from the Subcontractors, if applicable.

3. Covered Populations and Services

Section 3 Point Allocation	
Question(s)	**Points**
11	2
12	2
13	4
14	5
15	6
16	6
Total	25

Q11. Describe how the Respondent plans to integrate and ensure access to comprehensive primary care, specialty care, pharmacy, and Behavioral Health Services for all Members.

Q12. Describe the Respondent's process and procedures for providing Post-Stabilization Services.

Q13. Describe the Respondent's process and procedures for coordinating and facilitating Non-Emergency Medical Transportation (NEMT) for Members.

Q14. EPSDT provisions are a core requirement for the provision of services to children. Please describe the Respondent's:

1) Process for ensuring coverage of services that are Medically Necessary to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination for Members younger than twenty-one (21);

2) Outreach and communication strategies that enhance Member education on EPSDT requirements and improve compliance with the periodicity schedule and treatment recommendations that are identified as a result of a screening; and

3) Monitoring approach to ensure compliance with EPSDT requirements described in Section 4.1.8 (Early and Periodic Screening, Diagnostic, and Treatment) of the MCM Model Contract throughout all relevant departments within the managed care plan and with Subcontractors.

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Q15. Indicate the Value-Added Services that are not offered under the Medicaid State Plan and for which the cost of services would not be included in Capitation Payment calculations. The Respondent should indicate which Value-Added Services it plans to offer to all Members, and, in particular, whether the Respondent will include the following**:**

1) Mental health and/or Substance Use Disorder-related treatment services beyond what is required by the MCM Model Contract (e.g., Peer Recovery Support Services (PRSS) in excess of those required under the MCM Model Contract); and/or

2) Social supports for Members identified as having high unmet resource needs (as described in Section 4.10.10 (Coordination and Integration with Social Services and Community Care) of the MCM Model Contract) beyond those required under the MCM Model Contract.

Q16. Describe the Respondent's experience providing In Lieu of Services, pursuant to 42 CFR 438.3, which In Lieu of Services listed in the MCM Model Contract that the Respondent will provide to MCM Members in New Hampshire if selected; and which additional services the Respondent would like to provide subject to DHHS approval**.**

4. Pharmacy Management

Section 4 Point Allocation	
Question(s)	**Points**
17	35
18-19	35
Total	70

Q17. Describe the Respondent's plans for providing pharmacy benefits management and the processes that will be employed for oversight, monitoring, and analysis of pharmacy benefits management performance. Please also describe in detail how the Respondent will ensure that all MCM Model Contract requirements, including those related to data reporting and exchange with DHHS, Providers, and Members, will be completed.

Q18. Describe the Respondent's plan for providing Medication Management (as described in Section 4.2.5 (Medication Management) of the MCM Model Contract) to all Members. The description should include**:**

1) How the Respondent would identify Members at greatest need for medication management, including how the medication review will incorporate use of pharmacy claims, Provider reports, comprehensive assessments and care plans, contact with the Member's Provider(s) (including DCYF and residential or other treatment entities), current diagnoses, current behavioral health functioning, and information from the Member and the Member's family;

2) The Respondent's proposed approach to conducting medication review and counseling, particularly for Members at risk of harm due to polypharmacy; and

3) The Respondent's approach to providing active and comprehensive medication management for Children with Special Health Care Needs.

Q19. On the basis of the Respondent's experience to date, please include a description of improvements made by the Respondent as a result of implementing medication management initiatives, amongst similar populations as those covered in the MCM program. The description should include statistically valid results.

5. Member Enrollment and Disenrollment

Section 5 Point Allocation	
Question(s)	**Points**
20-22	11
23-24	8
25-26	11
27	N/A
Total	30

Q20. The Respondent shall describe how it will accept and process the State-supplied enrollment files, including policies and procedures for enrollment transactions. The policies and procedures should address initial connectivity to State systems, ability to capture enrollments, timing of accepting the transactions, successful acceptance of the transaction into the system (including downstream systems such as Care Management). Provide a flow chart and/or detailed diagrams for the pathways described.

Q21. Describe procedures for processing and monitoring enrollment/disenrollment files to ensure Members are enrolled/disenrolled within the designated timeframe after receiving notification from the State.

Q22. Describe how the Respondent will monitor the enrollment process including the processing of enrollment files, timely issuing of Member identification cards, and mailing initial Member materials.

Q23. Describe the Respondent's strategy and experiences with assisting Members in retaining their Medicaid eligibility at redetermination.

Q24. Describe the support and strategies the Respondent will employ to assist Members who transition in and out of the MCO due to loss of Medicaid eligibility.

5.1. MCO Role in Work and Community Engagement Requirements for Granite Advantage Members

Q25. Describe how the Respondent will work collaboratively with DHHS to support the ongoing operations of Work and Community Engagement requirements for Granite Advantage Members, as described in Section 4.3.1.1 (MCO Role in Work and Community Engagement Requirements for Granite Advantage Members) of the MCM Model Contract. Describe in detail:

1) The methods and modalities the MCO will use to conduct General Outreach and Member Education Activities;

2) The specific Member Support Services the Respondent will provide, particularly assistance related to supporting State processes for reporting compliance; and

3) The Respondent's plan for conducting targeted outreach activities for "mandatory non-compliant" Granite Advantage Members, including the overall approach and specific modalities it will employ.

Q26. DHHS is in the process of developing and defining the parameters by which the MCO will be required to use claims and Encounter Data to identify exempt and potentially exempt Members, as described in the MCM Model Contract. The Respondent should provide innovative ideas for best identifying the indicated Members and how the MCO's capabilities will best support this need.

5.2. Auto-Assignment

5.2.1. To the extent an MCO or MCOs that currently participate in the MCM program are selected in the re-procurement, DHHS is committed to maintaining continuity of coverage for Members, while identifying a pathway to ensuring that incoming MCO(s) receive an equitable share of Member enrollment. DHHS will institute an auto- assignment process that ensures Members are able to remain in their existing MCO, while providing a pathway for incoming MCO(s) to gain an equitable share of Members. In future years, DHHS plans to use the auto-assignment methodology to prioritize the assignment of Members based on each MCO's relative performance against State priorities including but not limited to quality and APM performance.

Q27. In light of these DHHS priorities, please provide:

1) The minimum number of Members the Respondent would expect to cover within six (6), twelve (12), and eighteen (18) months of the contract effective date; and

2) Whether there is a maximum number of Members the Respondent would expect to cover within six (6), twelve (12), and eighteen (18) months of the contract effective date.

6. Member Services

Section 6 Point Allocation	
Question(s)	**Points**
28-29	10
30-32	6
33	4
Total	20

Q28. Provide an organizational chart of the Member Services Department, showing the placement of Member Services within the Respondent's organization and the key staff within the Member Services Department.

Q29. Describe the Respondent's call center management experience in other states and anticipated approach for the MCM program, including:

1) The location of operations (if out-of-state, describe how the Respondent will accommodate services for New Hampshire);

2) The call center performance metrics that will be implemented including how the Respondent will meet minimum abandonment and speed of answer requirements indicated in Section 4.4.4.1 (Member Call Center) of the MCM Model Contract;

3) The processes used for conducting the Welcome Call and early rates of success in reaching Members for such calls;

4) The way in which the Respondent will determine staffing levels;

5) The process that will be used to conduct warm transfers (including any training to be provided); and

6) The plan to ensure a single, integrated Member service line for physical and behavioral health.

Q30. In a scenario where a Member who is hard of hearing calls the Member Services Department due to trouble scheduling an appointment with a Participating Provider, describe the steps and mechanisms that the Respondent will use to identify the caller's concern and document, track, and resolve the issue.

Q31. Describe the mechanisms in place, including specific language assistance capabilities, services and supports, to help potential Members and Members with Limited English Proficiency (LEP), disabilities, special health care needs, and

diverse cultural and ethnic backgrounds. Indicate how the Respondent will identify, monitor and address cultural and linguistic disparities among Members.

Q32. Describe how the Respondent will ensure cultural competency throughout the Respondent's Participating Provider network.

Q33. Describe how the Respondent will approach the composition and processes of the Member Advisory Board (Section 4.4.6.1) of the MCM Model Contract, including:

1) How the Respondent will determine and ensure that there is sufficient representation of populations covered under the MCM program; and

2) How the Respondent will accommodate Members with disabilities to ensure their full participation on the Member Advisory Board.

7. Member Grievances and Appeals

Section 7 Point Allocation	
Question(s)	**Points**
34	4
35	8
36-37	8
Total	20

Q34. Describe the Grievances Process the Respondent will use. Describe the process and timing for addressing a Member's dissatisfaction with any aspect of their care, including which staff will be involved.

Q35. Describe the process and timing for reviewing an Appeals request, including the process and timing for addressing standard and expedited appeals requests.

Q36. Provide a flowchart that depicts the process the Respondent will employ, from the receipt of the appeals request through each phase of the review to notification of disposition, including providing notice to the State Hearing Process.

Q37. Describe how data resulting from the Member Grievance and Appeals Processes will be tracked and used to improve the operational performance of the MCO.

8. Provider Appeals

Section 8 Point Allocation	
Question(s)	**Points**
38-39	10
Total	10

Q38. Describe the Provider Appeals Process the Respondent will employ, in compliance with NH standards and requirements as outlined in the MCM Model Contract.

Q39. Specify the supports and management efficiencies employed by the Respondent to ensure that Provider administrative burden is kept to a minimum, processes are clearly communicated, and inquiries are readily responded to in a timely manner resulting in a demonstrated low volume of Provider Appeals.

9. Access

Section 9 Point Allocation	
Question(s)	**Points**
40-41	22
42	8
Total	30

Q40. Describe existing relationships the Respondent has with relevant Providers and stakeholders in New Hampshire, if any. Which relationships does the Respondent anticipate forming?

Q41. Describe in detail how the Respondent will build a sufficient and effective network of Participating Providers that promotes Member-centered care, promotes choice of Provider, engages Member's informal support system (e.g., family caregivers), and provides care in the most integrated setting for Members. Provide a detailed example of the Respondent's approach in another state's Medicaid managed care market, addressing, if possible, how the Respondent has overcome a limited supply of Providers in rural areas.

Q42. In building the Respondent's Participating Provider network and contracting with Providers, describe how the Respondent will ensure the ability of Participating Providers to provide physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid Members with physical or mental disabilities, as required by 42 CFR 438.206(c)(3).

10. Utilization Management

Section 10 Point Allocation	
Question(s)	**Points**
43, 45	15
44, 46	15
Total	30

Q43. What strategies has the Respondent employed or does the Respondent currently employ in other state Medicaid markets to contain health care spending while ensuring Members maintain access to high-quality health care services? Describe how the Respondent plans to apply these strategies and any additional or new strategies in New Hampshire.

Q44. In alignment with MCM Model Contract requirements, describe the Respondent's approach to Utilization Management and how the approach would be modified for New Hampshire, including the Respondent's process to ensure the MCO Utilization Management Program includes criteria that:

1) Are practicable, objective and based on evidence-based criteria, to the extent possible;

2) Are based on current, nationally accepted standards of medical practice and are developed with input from appropriate actively practicing practitioners in the MCO's service area, and are consistent with the Practice Guidelines described in Section 4.8.2 (Practice Guidelines and Standards);

3) Are reviewed annually and updated as appropriate, including as new treatments, applications, and technologies emerge (DHHS shall approve any changes to the clinical criteria before the criteria are utilized);

4) Are applied based on individual needs and circumstances (including social determinant of health needs);

5) Are applied based on an assessment of the local delivery system;

6) Involve appropriate practitioners in developing, adopting and reviewing the criteria; and

7) Conform to the standards of NCQA Health Plan Accreditation.

Q45. Describe the processes the Respondent will implement for ED utilization review and identification of Members with high utilization, including use of Admission, Discharge and Transfers (ADT) feeds to identify Members with one (1) or more ED visit. What strategies will the Respondent implement to reduce high ED utilization? Provide statistically relevant results of initiatives employed in a program similar to the MCM program wherever possible.

Q46. Describe the Respondent's management techniques, policies, procedures or initiatives in place or that will be place by the Program Start Date to effectively and appropriately control avoidable hospitalizations and readmissions. Provide statistically relevant results of initiatives employed in a program similar to the MCM program if possible.

11. Member Education and Incentives: MCOs participating in the MCM program will be expected to develop a Member health education program that promotes and supports the overall wellness of Members, with the goal of empowering Members to actively participate in their care. In alignment with this goal, the MCO is required (as described in Section 4.9.4 (Member Incentive Programs) of the MCM Model Contract) to develop Member Incentive Programs designed to achieve these goals.

Section 11 Point Allocation	
Question(s)	**Points**
47	35
48	25
Total	60

Q47. Describe the Respondent's plan for implementing at least one (1) Healthy Behavior Incentive Program and at least one (1) Reference-Based Pricing Incentive Program, as described in the MCM Model Contract. For each program proposed, describe:

1) How Members eligible for the program will be identified and enrolled in the program;

2) The target number of Members for the program;

3) How preferred Providers and services will be identified and communicated to Members;

4) The types of incentives that will be offered to Members (including the dollar value of cash incentives and any other incentives that will be provided); and

5) How Members will earn and lose points based on changes in behavior over a period of time.

6) The Contractor shall describe processes for capturing and storing the data necessary for qualifying activities and programs.

Q48. If applicable, the MCO should provide an example of its experience administering a Member Incentive Program for a similar population and/or with similar objectives, and include:

1) The target population for the Member incentive program;

2) How individuals were identified for participation in the Member incentive program;

3) The number of individuals that ultimately enrolled in the program, and received incentives for participation; and

4) Any statistically relevant program results, particularly those that demonstrate a change in Member behavior and/or improved health outcomes.

12. Care Coordination and Care Management: High-performing Care Coordination and Care Management are fundamental to the added value DHHS seeks through its relationship with Medicaid MCOs. DHHS is seeking responses that will clearly describe Care Coordination and Care Management strategies that are targeted at improving Member care and health outcomes, reducing inappropriate hospitalizations and utilization of Emergency Services, addressing unmet resource needs, better integrating primary and behavioral health, providing Local Care Management, and decreasing the total cost of care.

Section 12 Point Allocation	
Question(s)	**Points**
49(1)	5
49(2)(a), (2)(b), (2)(c)	10
49(2)(d), (2)(e), (2)(f)	20
49(2)(g), (2)(h), (2)(i),	20
49(3)	5
49(4), (5), (6)	15
50-54	25
Total	100

Q49. Provide a description of the Respondent's structure and plan for Care Coordination and Care Management inclusive of key components of each program, type of service provided, roles and responsibilities of staff involved in the provision of each service and how Members will be identified for Care Coordination versus Care Management.

1) Describe the plan for Care Coordination, including: a description of Care Coordination functions; and key activities and performance expectations.

2) Describe the plan for Care Management, including:

a) A description of the process and timing for conducting a Health Risk Assessment of every Member within ninety (90) days of the effective date of MCO enrollment; the identification, Risk Scoring and Stratification process, tools and methods that the Respondent will use for identifying the Priority Populations as required in the MCM Model Contract;

b) A description of the plan and methodology for conducting Risk Scoring and Stratification;

c) A description of the process and timing for conducting a Comprehensive Assessment for high-risk, high-need Members identified, including how such Members will be identified, the content that will be included in the Comprehensive Assessment and how frequently re-assessments will be conducted;

d) A description of the Care Management that will be provided to high risk high-need individuals identified as Priority Populations including, at a minimum, the coordination of physical, behavioral health and social services, regular medication reconciliation, referral follow-up, peer support, training on self-management, assistance with meeting unmet resource needs, and the convening of local community based care teams, including the frequency of such convenings. The description should include the projected share of Members that will be classified as high risk high and engaged in active Care Management based on the Respondent's current Medicaid managed care experience and proposed approach in New Hampshire. Please provide rationale for percentage of Members enrolled in active Medicaid Care Management as high risk. The description should include identification for the percent and/or number of Members engaged in active Care Management, either by direct MCO staff or contracted agencies or in known identified relationships with the MCO;

e) A description of the qualifications and competencies of the Respondent's care managers;

f) A description of all the components of the Respondent's Care Plan as described in Section 4.10.6 (Care Management for High Risk and High Need Members) of the MCM Model Contract, including how frequently it will be updated; A description of an end-to-end description of the process and timing for conducting Transitional Care Management for all Members moving from one clinical setting to another to prevent unplanned or unnecessary readmissions, emergency department visits or other adverse outcomes;

g) A description of the process and approach for providing Local Care Management, to the maximum extent possible, and in compliance with the MCM Model Contract. The description should include in the proposal for providing face-to-face Care Management support and how the MCO will coordinate with Designated Care Management Entities. Responses must include a description of the Designated Care Management Entities that will be leveraged, if applicable, including whether they are IDNS or other contracted entities capable of performing Local Care Management for a designated cohort of MCO Members. Propose a projected percentage of high-need Members who will be provided local face-to- face Care Management in the community in alignment with the MCM Model Contract

h) Provision of an end-to-end description of the process the Respondent will employ to provide Care Management for a Child With Special Health Care Needs, from the initial care needs screening through each phase of the Care Management process. Description should include the process for initially and periodically assessing Children with Special Health Care Needs and identify the staff performing the assessments and their credentials; and

i) A description of whether the Respondent will include contractual relationships, if any, that support the Respondent's ability to coordinate care, including information sharing and care planning, for a Member among multiple Providers. Include a description of the contractor(s) and role.

3) Describe the Respondent's experiences and the approaches it will use to coordinate comprehensive services, including primary care, acute care, and behavioral health. A description of the Care Management-to-Member staffing ratios and how they may vary based on acuity of the Member should be included.

4) Provide concrete examples of working with entities similar to IDNs to support the implementation of Local Care Management. What challenges did the Respondent face and how were they mitigated?

5) To address New Hampshire's key priorities, describe how the Respondent will work with IDNs in alignment with the goals and requirements set forth by DHHS in the MCM Model Contract, including:

a) What the Respondent envisions to be the delineation of roles and responsibilities between the MCO and IDNs, addressing specific provisions described in the MCM Model Contract; and

b) How the Respondent will coordinate data collection and ensure data sharing with IDNs that is consistent with DHHS's goals.

6) Describe the approach the Respondent will take to incorporating the Wellness Visit (as described in Section 4.10.2.8 of the Model Contract) into its care coordination and care management approach, and its broader connection to the MCO's approach to identifying high-needs Members, and providing integrated behavioral and physical health care.

Q50. Describe the Respondent's competencies and approach to addressing social needs for Members, including promoting access to stable housing, healthy food, reliable transportation, interpersonal safety, and job support.

Q51. Describe the Respondent's competencies and approach in addressing social determinants of health as part of the initial Health Risk Assessment Screening and Risk Scoring and Stratification processes. Describe how the Respondent will identify whether the Member is in need of services that address social determinants of health and, in particular, how the Respondent will identify homeless individuals and assist with housing as described in the MCM Model Contract, as well as provide supports for Members facing multiple barriers to food and transportation.

Q52. Describe the Respondent's experience addressing social determinants of health in Comprehensive Health Assessments and how "warm handoffs," closed loop referrals, or other approaches to helping Members secure needed services are integrated into the Respondent's Care Management strategy or related policies and protocols.

Q53. For the three (3) preceding questions, provide specific examples of how the Respondent has supported these functions in other Medicaid markets, and all results, measurable outcomes, achieved from the Respondent's applied interventions.

Q54. Describe the local relationships and processes that the Respondent will use in New Hampshire to make referrals to local social services and community care and follow up to ensure that Members are successful in addressing unmet resource needs.

13. Behavioral Health (Mental Health and Substance Use Disorder)

Section 13 Point Allocation	
Question(s)	**Points**
55(1), (2), (3)	20
55(4)	10
56	5
57	5
58	15
59	5
60, 61	10
62, 63	10
64	10
65, 66	10
Total	100

Q55. Describe the strategies the Respondent will implement in the delivery and coordination of Behavioral Health Services and supports, including:

1) Whether the Respondent intends to use a Subcontractor for the delivery of Behavioral Health Services;

2) A description of the way in which the Respondent will promote integrated physical and behavioral health (including the strategies the Respondent will use to promote the integration of Behavioral Health Services in physical health settings and the provision of physical health services in behavioral health settings consistent with the SAMHSA model for Integrated Care). If the Respondent is using a Subcontractor, please describe the processes that will be deployed to maximize use of fully Integrated Care;

3) How the Respondent will comply with all Behavioral Health staffing requirements (including training and education) as required under the MCM Model Contract, taking into account the limited supply of behavioral health Providers in New Hampshire, and how the MCO can best support workforce needs; and

4) The Respondent's plan to use incentive payments or MCO APMs to advance behavioral health goals.

Q56. Describe the Respondent's capacity to provide the required mental health services as outlined in the MCM Model Contract.

Q57. Describe the strategies and actions the Respondent will take to reduce psychiatric boarding stays in the ED and in other hospital settings for Medicaid enrollees (regardless of whether they are dual-eligible individuals), including a description of the following:

1) The Respondent's approach to having on staff or contracting with a sufficient number of clinical Providers who are credentialed by the hospital (i.e., "hospital-credentialed Providers") to provide services to reduce psychiatric boarding stays; and the additional capacity the Respondent will leverage beyond coordination with CMH Programs and Providers (e.g., Assertive Community Treatment (ACT) teams).

2) The Respondent's proposed approach to a clinical performance improvement project (PIP) designed to reduce psychiatric boarding in the ED.

3) To the degree applicable, any statistically relevant results of intervention(s) implemented by the Respondent in other states.

4) The Respondent's plan for establishing Provider reimbursement and payment methodologies that create appropriate financial incentives to reduce psychiatric boarding and enhance timely discharges from hospitals.

Q58. As indicated in the MCM Model Contract, MCOs will be required to enter into capitated payment arrangements with CMH Programs/CMH Providers,[1,2] providing for reimbursement on terms specified by DHHS in forthcoming guidance. Describe the Respondent's ability to support capitated contract arrangements with community mental health centers and experience supporting these or similar arrangements in other states, including functions such as:

1) Processing timely prospective payment from a Member eligibility list provided by the CMH Program/CMH Provider (or similar provider);

[1] https://www.dhhs.nh.gov/dcbcs/bbh/centers.htm
[2] http://www.gencourt.state.nh.us/rules/state_agencies/he-m400.html

2) Determining whether Members are eligible for capitation payments, or should be paid on a FFS basis to the CMH Program/CMH Provider (or similar provider);

3) Providing detailed MCO data submissions to DHHS and the CMH Program/CMS Provider (or similar provider) for purposes of reconciling payments and performance (e.g., 835 file); and

4) Establishing a coordinated effort for Substance Use Disorder treatment in collaboration with CMH Programs/CMH Providers (or similar provider). Describe the Respondent's strategies and actions it will utilize to increase suicide prevention awareness and promote suicide prevention programs broadly in New Hampshire.

Q59. Describe the Respondent's strategies and actions it will utilize to increase suicide prevention awareness and promote suicide prevention programs broadly in New Hampshire.

Q60. Describe the Respondent's capacity to provide the required Substance Use Disorder services as outlined in the MCM Model Contract.

Q61. Describe how the Respondent will ensure and monitor that the full continuum of care is available to Members with a Substance Use Disorder and the Respondent's experience in other states addressing Provider shortages or other gaps in Substance Use Disorder treatment services.

Q62. Describe the Respondent's plans to promote use of MAT in New Hampshire and the Respondent's experiences in other states increasing use of MAT, providing statistically- relevant data if possible.

Q63. Describe the Respondent's plans to screen for and treat babies born with NAS and their families, providing specific examples of the Respondent's work in other states and any statistically-relevant results.

Q64. Describe the steps the Respondent will take to contract with and have in its network all willing Peer Recovery Providers and methadone clinics in New Hampshire. The response must include examples of the Respondent's experiences in other states integrating such Providers into its delivery network and how the Respondent has worked with such Providers in the past. This response should also include how the Respondent would work with existing and new Provider organizations to ensure proper Medicaid reimbursement practices are in place.

Q65. Describe how the Respondent will safely reduce the rate of opioid prescribing without increasing use of illicit opioids, including, but not limited to:

1) Strategies for working with Providers to reduce opioid prescribing;

2) Supporting Providers in alternative strategies for addressing pain;

3) Providing assistance to Members who are chronic or high users of opioids;

4) Using the New Hampshire Prescription Drug Monitoring Program (PDMP) and/or opioid prescribing data to monitor and change prescribing patterns; and

5) Any additional strategies that the Respondent has found effective in other states for safely reducing use of prescription opioids.

Q66. Describe how the Respondent will track and ensure timely treatment for and follow up with Members who have an ED visit or are hospitalized due to an overdose.

14. Health Homes and Children with Special Health Care Needs

Section 14 Point Allocation	
Question(s)	**Points**
67	40
68	10
Total	50

14.1 Health Homes:
DHHS is committed to ensuring that evidence-based treatment models to address the State's opioid epidemic and to improve access to behavioral/mental health services are considered. DHHS plans to implement Health Homes as authorized under Section 2703 of the Patient Protection and Affordable Care Act within twenty four (24) months of the beginning of the Agreement Term. The State's intent is to allow as much innovation as possible with all MCOs in the adoption, design, and implementation of Health Homes.

Q67. Please detail:

1) The Respondent's capabilities and proposed approach for coordinating with Health Homes, taking into consideration the current MCM Model Contract requirements for behavioral health, mental health, and Substance Use Disorder.

2) DHHS intends for Health Homes to incorporate a Member's current community based Provider wherever possible and leverage, when practicable, the IDNs construct and capacity. Indicate how the Respondent will incorporate existing service structures Members currently access into Health Homes.

3) Explain how the Respondent would support the implementation of Health Homes in New Hampshire and describe your experience is providing such services in another Medicaid market.

14.2 Children with Special Health Care Needs
DHHS is committed to ensuring the unique needs of Children with Special Health Care Needs are met through the Medicaid managed care delivery system. DHHS is currently exploring whether to develop a separate Medicaid managed care product, with adjusted capitation rates and tailored contractual requirements that would be exclusively offered to children with complex physical and behavioral health care needs.

Q68. Please detail:

1) The Respondent's capabilities and approach for addressing the current MCM Model contract requirements designed for Children with Special Health Care Needs including medication management, network adequacy, access to Providers during transitions of care and Provider supports; and

2) The Respondent's interest in offering a separate product for Children with Special Health Care Needs at a future date. Please describe your experience with providing such tailored services in another Medicaid market.

15. Quality Management

Section 15 Point Allocation	
Question(s)	**Points**
69	8
70-71	10
72-74	12
Total	30

15.1. Health Plan Accreditation

Q69. The Respondent shall specify its current health plan accreditation status for all markets in which it is currently participating. This shall include:

1) The name of the accrediting entity (e.g., NCQA, Utilization Review Accreditation Commission (URAC));

2) The most recent date of certification;

3) The effective date of the accreditation;

4) The type(s) and corresponding level(s) of accreditation achieved; and

5) The status of the accreditation (e.g., provisional, conditional, etc.).

15.2. Quality Assessment and Performance Improvement Program

Q70. Describe the Respondent's plan for establishing and implementing an ongoing QAPI Program inclusive of all elements specified in the MCM Model Contract.

Q71. Provide an organizational chart that indicates what the relationship of the QAPI program would be to Respondent leadership, and how the Respondent's QAPI program relates to the Respondent's processes for Utilization Management, the development and implementation of clinical Practice Guidelines, Provider relations, etc.

Q72. Provide one or more detailed examples of how, in another Medicaid managed care market, the Respondent's QAPI program was utilized to identify a necessary improvement, implement an initiative designed to address the challenge, modify the initiative based on ongoing assessment. Describe statistically relevant outcomes achieved as result of implementing the improvement.

APPENDIX D – Mandatory Responses to Technical Components of the RFP

Q73. Provide the Respondent's most recent two (2) years of Medicaid Managed Care results for all available HEDIS and CAHPS quality measures required by DHHS, as described in Exhibit O of the MCM Model Contract (*note: HEDIS and CAHPS measures are a subset of the measures included in Exhibit O; DHHS is not requesting all measures and reports described in Exhibit O for purposes of responding to this question)*. This information should be conveyed in a table, broken out by Medicaid managed care plan, and include the following information:

1) The name and location of the plan;

2) The total membership of the plan; and

3) A description of the population reflected in the results.

Q74. If, in response to the previous question, the MCO is unable to provide Healthcare Effectiveness Data and Information Set (HEDIS) results for at least three (3) Medicaid contracts, the Respondent should provide commercial HEDIS measures for the Respondent's largest (in number of lives) contracts. If the Respondent is located in New Hampshire, New Hampshire-based results should be prioritized for inclusion in the Respondent's Proposal over larger, out-of-state contracts.

16. Network Management

Section 16 Point Allocation	
Question(s)	**Points**
75	10
Total	10

Q75. Ongoing Provider support is important to ensuring Members' access to and the delivery of high-quality care. DHHS is committed to improving the Provider credentialing process and exploring opportunities to centralize Provider credentialing in the near future. Please describe the Respondent's proposed approach for:

1) Conducting Provider outreach and communications when programmatic changes are made;

2) Meeting the Provider training requirements as required in the MCM Model Contract;

3) Implementing a prompt and accessible credentialing and re-credentialing process that will be used to conduct outreach and supports to Providers (note: DHHS's requirement is that all PCP Providers be credentialed within thirty (30) days and all specialty Providers be credentialed within forty-five (45) days);

4) Standardizing work processes between DHHS and Participating Providers ensure efficient implementation of the MCM program and minimal Provider burden relative to claims billing processes, reporting, prior authorizations, etc.; and

5) Providing technical assistance to Participating Providers, especially for Participating Providers with which the Respondent would be implementing high- priority interventions (e.g., with Substance Use Disorder Providers, with Behavioral Health Providers and PCPs on the integration of physical behavioral health, with Provider participants in MCO Alternative Payment Models, etc.).

17. Alternative Payment Models: DHHS is committed to implementing clinically and actuarially sound incentives designed to improve care quality and utilization, and also recognizes that there is not a "one size fits all" approach to implementing APMs for the many types of Providers that serve MCM Members. As indicated in Section 4.14 (Alternative Payment Models) of the MCM Model Contract, DHHS will issue a Medicaid APM Strategy that may include supporting guidance, worksheets, and templates that will build upon the parameters set forth in the MCM Model Contract. In the interim, DHHS is interested in understanding how the Respondent would propose to implement APMs that meet DHHS's goals and requirements as described broadly and as specifically related to APMs, as described in Section 4.14 (Alternative Payment Models) of the MCM Model Contract.

Section 17 Point Allocation	
Question(s)	**Points**
76-77	25
78	15
Total	40

Q76. Submit to DHHS an initial proposed APM Implementation Plan, including all required components described within the MCM Model Contract. DHHS recognizes that this Implementation Plan may require further iteration based upon DHHS's issuance of the DHHS Medicaid APM Strategy. The APM Implementation Plan shall clearly describe what steps the MCO will take at Program Start, and within the first 6, 12, and 18 months of implementation of the MCM Agreement, including:

1) The Respondent's approach to ensuring that 50% of all MCO medical expenditures are in Qualifying APMs within the timeline prescribed by the MCM Model Contract and consistent with DHHS's overall objective to promote the goals of the Medicaid program;

2) The Respondent's approach to implementing a total cost of care model with upside only shared savings for large Provider systems to the maximum extent feasible;

3) The Respondent's approach for making accommodations for small Providers;

4) How the Respondent will align its approach with the HCP-LAN APM framework and existing APM models, including those that are aligned to

"Other Payer Advanced Alternative Payment Models" under the requirements of the Quality Payment Program as set forth by MACRA;

5) How the Respondent will adhere to all APM model transparency and reporting requirements outlined within the MCM Model Contract;

6) The Respondent's approach, consistent with the requirements outlined in the MCM Model Contract, to Provider engagement and data sharing.

Q77. For all proposed APM models included in the Respondent's APM Implementation Plan, clearly articulate how the Respondent will be transparent both in contracting with Providers and with DHHS on all elements of the Respondent's APM offerings, including:

1) How Member attribution will be determined, the frequency at which attribution will be re-assessed, and how Providers will be proactively made aware of the Members attributed to the Provider on a timely and actionable basis;

2) The risk adjustment methodology that will be applied;

3) The methodology for developing cost targets and the frequency at which participating Providers will receive that information;

4) The methodology for developing quality targets and the frequency at which participating Providers will receive that information;

5) How Provider performance against the cost target will be assessed;

6) By providing a sample reporting template that will be shared with Provider APM participants to support concurrent utilization management as well as retrospective information for the development of an performance under the MCO's proposed APM models;

7) The method and frequency of reporting to Provider participants in APMs; and

8) In the interest of support DHHS's development of a standard APM reporting template, a proposal for how the MCO recommends it and other MCOs participating in the MCM program should submit quarterly APM results in a Standard Template.

Q78. To the extent the Respondent has prior experience implementing APMs (or similarly defined payment models) among its provider network(s), the Respondent should include a table indicating all of its current APM arrangements across all lines of business and states. The table should include:

1) Name of the APM program;

2) Line(s) of business to which the program applies (e.g., Medicaid, Medicare Advantage, etc.);

3) State(s) in which the program applies;

4) Whether the arrangement was required by the state and, if so, under what state program;

5) Description of the APM program;

6) The method of attributing members;

7) The total member lives and member months attributed to the APM;

8) The applicable HCP-LAN APM category/sub-category (e.g., Category 2C) in which the arrangement best fits;

9) Provider types governed under the arrangement, and the percentage of APM expenditures each provider type represents;

10) Service types governed under the arrangement;

11) Quality requirements included as part of the arrangement;

12) Percent of total Medicaid spending (including drug spending) governed under the arrangement for the relevant line of business in the most recent 12-month measurement period;

13) Percent of total Medicaid spending (including drug spending) projected to be governed under the relevant line of business in the next 12-month measurement period;

14) Total payments (or negative payments) made to provider participants based on their performance in the APM; and

15) Any other metrics or information determined by the Respondent to be important to the success or failure of the APM.

18. Provider Payments

Section 18 Point Allocation	
Question(s)	**Points**
79-80	10
Total	10

Q79. Describe the Respondent's process for meeting the prompt payment requirements described within the MCM Model Contract.

Q80. Describe the Respondent's process for paying claims based on the effective date of the Current Procedural Terminology (CPT) code.

19. Claims Quality Assurance and Reporting

Section 20 Point Allocation	
Question(s)	**Points**
81-85, 87	6
86	4
Total	10

Q81. Please submit a flow chart and narrative of the Encounter Data submission process the Respondent will employ in NH, including but not limited to, how accuracy, timeliness, and completeness of data will be ensured.

Q82. Completeness of Encounter Data submissions requires that key fields are populated accurately for every encounter submission; describe the quality control processes that will ensure key fields are accurately populated when encounters are submitted.

Q83. Indicate what quality control procedures the Respondent will use to ensure documentation and coding of encounters are consistent throughout all records and data sources and across Providers and Provider types. The description should include tracking, trending, reporting, process improvement, and monitoring of encounter submissions, encounter revisions, and its methodology for eliminating duplicate data.

Q84. Indicate any feedback mechanisms that the Respondent will use to improve Encounter Data accuracy, timeliness, and completeness, and the tools and methodologies that will be used to determine compliance with Encounter Data submission requirements.

Q85. Include documentation of the Respondent's most recent three (3) years of Encounter Data submission compliance ratings for at least one Medicaid managed care contract arrangement. The documentation should be an assessment completed either by DHHS (the Medicaid Agency or the Agency with which the Respondent was contracted) or the External Quality Review Organization.

Q86. Describe how the Respondent will work with Providers – particularly subcapitated Providers, Subcontractors, and Non-Participating Providers – to ensure the accuracy, timeliness, and completeness of Encounter Data.

Q87. Provide a table listing all instances in the last five (5) years and for all Medicaid managed care contracts in which the Respondent was: (1) delayed in submitting Encounter Data; (2) unable to submit Encounter Data; and/or (3) otherwise out of compliance with a state's requirement to provide Encounter Data.

20. Oversight and Accountability

Section 20 Point Allocation	
Question(s)	**Points**
88	3
89-90, 93-94	6
91-92, 95	19
96-97	2
Total	30

Q88. Please indicate the number of times, over the past five (5) years, that punitive action has been taken against the Respondent (i.e. required to submit CAPs, monetary or non- monetary penalties imposed, Capitation Payments withheld, etc.) by state Medicaid agencies. Describe the reason each action was taken and what the Respondent did to improve performance in response to the action.

Q89. Provide a copy of the following:

1) Policies and procedures demonstrating compliance with 42 CFR Section 438.608.

2) Policies and procedures regarding recovery, reporting and tracking of Overpayments.

3) Policies and procedures on collection and maintenance of information on ownership and control to demonstrate compliance with Sections 3.10.3 (Ownership and Control Disclosures) and 5.3.7 (Access to Records, On-Site Inspections, and Periodic Audits) of the MCM Model Contract.

4) Policies and procedures demonstrating compliance with False Claims Act, and other federal and state laws described in Section 1902(a)(68) of the Social Security Act.

Q90. Describe how background and exclusion screenings, and the frequency of which, are conducted on:

1) Board Members

2) Employees

3) Vendors

4) Contractors

5) Subcontractors

Q91. Describe data analytic algorithms that will be used by the Respondent for purposes of fraud detection.

Q92. Describe the Respondent's specific controls to cost avoid and detect and prevent potential FWA including, without limitation:

1) A list of automated pre-payment claims edits, including National Correct Coding Initiative edits;

2) A list of automated post-payment claims edits;

3) A list of audits of post-processing review of claims planned;

4) A list of reports on Participating Providers and Non-Participating Providers profiling used to aid program and payment integrity reviews;

5) The methods MCO will use to identify high-risk claims and MCO's definition of "high-risk claims";

6) Visit verification procedures and practices, including sample sizes and targeted Provider types or locations;

7) A list of surveillance and/or Utilization Management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services;

8) A method to ensure that services represented as delivered by Participating Providers were received by Members;

9) A list of references in Provider and Member material identifying fraud and abuse reporting hotline number;

10) Work plans for conducting both announced and unannounced site visits and field audits of Providers determined to be at high risk to ensure services are rendered and billed correctly;

11) The process for putting a Provider on and taking a Provider off prepayment review, including, the metrics used and frequency of evaluating whether prepayment review continues to be appropriate; and

12) The ability to suspend Provider's payment due to credible allegation of fraud if directed by DHHS Program Integrity.

Q93. Describe the resources for FWA including the organization and reporting structure, and the number of Full Time Equivalents (FTEs).

Q94. Provide the Respondent's policy regarding how credible allegations of fraud or abuse shall be referred to DHHS Program Integrity.

Q95. Describe the Respondent's experience with Provider recovery collection. Provide any empirical evidence of the Respondent's collection success rate.

Q96. Describe any training programs that the Respondent's organization uses to train employees to recognize and report patterns of fraud and abuse.

Q97. Describe how the Respondent engages Members in preventing fraud and abuse.

21. Third Party Liability / Coordination of Benefits

Section 21 Point Allocation	
Question(s)	**Points**
98 & 101	10
99-100	10
102	10
103	10
104	10
Total	50

Q98. Describe how the Respondent will:
1) Query data sources to identify potential sources of TPL; and
2) Identify and maintain other potential TPL when adjudicating Members' claims.

Q99. Provide the number of FTE(s) that will be dedicated to TPL and COB identification and recovery and to whom they will report.

Q100. Describe how the Respondent will maximize the identification and recovery of TPL.

Q101. Describe the Respondent's method, process, and system edits for:
1) Capturing third-party resource and payment information from the Respondent's claims system; and
2) Cost avoiding through COB optimization.

Q102. Describe the process the Respondent uses for retrospective post-payment recoveries of health-related insurance, whether done by the MCO or a Subcontractor.

Q103. Describe the Respondent's TPL collection rate broken down by category when a third-party payer is identified for each of the organizations provided in response to Question 2 (under Managed Care Experience and References) of this RFP.

Q104. Describe the Respondent's process for sharing TPL and COB information with DHHS; and describe the Respondent's subrogation case tracking and process for cost avoiding and recovering funds related to subrogation cases and other TPL coverage.